Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PHYSICIAN MGMT SVCS DBA INJURY 1 TRTMT CTR

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-18-0179-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
SEPTEMBER 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT code 90901 x 4 units was performed and billed and the carrier only paid 1 unit on each date of service."

Amount in Dispute: $685.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on documentation received, Coventry stands behind our review."

Response Submitted by: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2017 February 20, 2017 February 27, 2017 March 6, 2017	CPT Code 90901(X4) Biofeedback training by any modality	$171.27 X 4 = $685.08	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the fee guidelines for reimbursement of professional medical services provided in the Texas workers' compensation system.
3. The services in dispute were reduced / denied by the respondent with the following reason code:
    - 00109-(45)-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - P300-The amount paid reflects a fee schedule reduction.
    - Z710-The charge for this procedure exceeds the fee schedule allowance.

- 00950-This bill is a reconsideration of a previously reviewed bill, allowance amounts do not reflect previous payment.
- W3-Request for reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What is the applicable fee guideline?
2. Is the respondent's denial of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The fee guidelines for professional services are found in 28 Texas Administrative Code §134.203.
2. According to the explanation of benefits, the respondent paid $57.09 for code 90901 based upon the fee guideline. The requestor is seeking reimbursement for an additional three units of code 90901.

   CPT code 90901 is defined as "Biofeedback training by any modality."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203 (b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   CPT code 90901 is defined as "Biofeedback training by any modality."

   A review of the submitted medical records finds the requestor wrote in each report "Baseline data was obtained. Biofeedback training included: pain control techniques, instructions in abdominal breathing, & guided imagery. Types of feedback: visual & audio." The division finds the requestor did not support billing code 90901 (X4). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/19/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.